Filing at a Glance

Company: Diamond State Insurance Company

Product Name: Social Services Program	SERFF Tr Num: PENN-125601891	State: Arkansas
TOI: 17.0 Other Liability - Claims Made/Occurrence	SERFF Status: Closed	State Tr Num: EFT $50
Sub-TOI: 17.0000 Other Liability Sub-TOI Combinations	Co Tr Num: DS-2008-PL-F-080	State Status: Fees verified and received
Filing Type: Form	Co Status:	Reviewer(s): Betty Montesi, Edith Roberts, Brittany Yielding
	Author: Lorna Geiger	Disposition Date: 04/16/2008
	Date Submitted: 04/10/2008	Disposition Status: Approved
Effective Date Requested (New): 06/01/2008		Effective Date (New):
Effective Date Requested (Renewal): 06/01/2008		Effective Date (Renewal):

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number: DS-2008-PL-F-080	Domicile Status Comments:
Reference Organization:	Reference Number:
Reference Title:	Advisory Org. Circular:
Filing Status Changed: 04/16/2008	
State Status Changed: 04/16/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Diamond State Insurance Company is filing a revision to its currently approved Social Services Program. We are submitting revised form APA-159 (01/2008), Social Service Agency Application, which will replace APA-159 (11/05) on approval. The following changes have been made to the form:

1. The Accident and Health section has been removed from page 7 of 11 along with questions 41 and 42 which applied to this section;

2. Questions 41 and 42 have been renumbered;

3. Reference to NIPC has replaced with CRC on page 10 of 11; and

4. The Reminder regarding Accident and Health has been deleted on page 11 of 11.

We are also submitting new form APA-159A (01/2008), Diamond State Group Social Services Agencies Application. Form APA-159 will be used for our MGA (CRC) and form APA-159A will be used for brokerage business. Form APA-159A is basically the same as APA-159 with the following changes:

1. The cover sheet has the following changes:

a) The Diamond State logo has been added;

b) The wording “Social Services Agency Application” has been moved down the page and is now referred to as “Social Services Agencies Application";

c) "CRC” has been deleted

d) The office address, telephone number, and fax number have been added in the lower right hand corner.

2. Questions 41 and 42 have been renumbered;

3. Reference to NIPC/CRC has been deleted ;

4. Check boxes labeled “Retailer” and “Wholesaler” have been removed on page 10 of 11;

5. The Reminder regarding Accident and Health has been deleted on page 11 of 11; and

6.The form has been renamed APA-159A (01/2008).

Company and Contact

Filing Contact Information

Lorna Geiger, State Filing Analyst
Three Bala Plaza East
Bala Cynwyd, PA 19004

lgeiger@unitednat.com
(610) 660-6876 [Phone]
(610) 668-3399[FAX]

Filing Company Information

Diamond State Insurance Company
Three Bala Plaza, East
Suite 300

CoCode: 42048
Group Code: 920

State of Domicile: Indiana
Company Type:

SERFF Tracking Number:	*PENN-125601891*	*State:*	*Arkansas*
Filing Company:	*Diamond State Insurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*DS-2008-PL-F-080*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0000 Other Liability Sub-TOI Combinations*
Product Name:	*Social Services Program*		
Project Name/Number:	*/DS-2008-PL-F-080*		

Bala Cynwyd, PA 19004
(610) 660-6825 ext. [Phone]

Group Name:
FEIN Number: 51-0257823

State ID Number:

SERFF Tracking Number:	*PENN-125601891*	*State:*	*Arkansas*
Filing Company:	*Diamond State Insurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*DS-2008-PL-F-080*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0000 Other Liability Sub-TOI Combinations*
Product Name:	*Social Services Program*		
Project Name/Number:	*/DS-2008-PL-F-080*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Diamond State Insurance Company	$50.00	04/10/2008	19427632

SERFF Tracking Number:	*PENN-125601891*	*State:*	*Arkansas*
Filing Company:	*Diamond State Insurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*DS-2008-PL-F-080*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0000 Other Liability Sub-TOI Combinations*
Product Name:	*Social Services Program*		
Project Name/Number:	*/DS-2008-PL-F-080*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	04/16/2008	04/16/2008
Approved	Edith Roberts	04/16/2008	04/16/2008

SERFF Tracking Number:	*PENN-125601891*	*State:*	*Arkansas*
Filing Company:	*Diamond State Insurance Company*	*State Tracking Number:*	*EFT $50*
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TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0000 Other Liability Sub-TOI Combinations*
Product Name:	*Social Services Program*		
Project Name/Number:	*/DS-2008-PL-F-080*		

Disposition

Disposition Date: 04/16/2008
Effective Date (New):
Effective Date (Renewal):
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PENN-125601891*	*State:*	*Arkansas*
Filing Company:	*Diamond State Insurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*DS-2008-PL-F-080*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0000 Other Liability Sub-TOI Combinations*
Product Name:	*Social Services Program*		
Project Name/Number:	*/DS-2008-PL-F-080*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Form	Social Services Agencies Application	Approved	Yes
Form	Social Services Agency Application	Approved	Yes

SERFF Tracking Number:	*PENN-125601891*	*State:*	*Arkansas*
Filing Company:	*Diamond State Insurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*DS-2008-PL-F-080*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0000 Other Liability Sub-TOI Combinations*
Product Name:	*Social Services Program*		
Project Name/Number:	*/DS-2008-PL-F-080*		

Disposition

Disposition Date: 04/16/2008
Effective Date (New):
Effective Date (Renewal):
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PENN-125601891*	*State:*	*Arkansas*
Filing Company:	*Diamond State Insurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*DS-2008-PL-F-080*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0000 Other Liability Sub-TOI Combinations*
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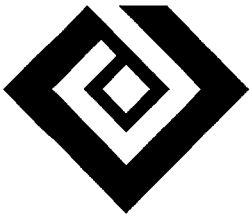
Filing Company:	*Diamond State Insurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*DS-2008-PL-F-080*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0000 Other Liability Sub-TOI Combinations*
Product Name:	*Social Services Program*		
Project Name/Number:	*/DS-2008-PL-F-080*		

Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Social Services Agencies Application	APA-159A	(01/2008)	Application/ New Binder/Enro llment		0.00	Form APA-159A (01-2008).pdf
Approved	Social Services Agency Application	APA-159	(01/2008)	Application/ Replaced Binder/Enro llment	Replaced Form #: APA-159 (11/05) Previous Filing #: 06-1PL-004	0.00	Form APA-159 (01-2008).pdf



Social Services Agencies Application

17550 N. Perimeter Drive,
Suite 240
Scottsdale, AZ 85255
Phone: 480-636-3400
Fax: 480-636-3418

Social Service Agency Application

This section is FOR OFFICE USE ONLY - Please do not complete.

☐ Diamond State Ins. Co. ☐ United National Ins. Co. ☐ United National Cas. Ins. Co. ☐ United National Spec. Ins. Co.

All questions must be completed to enable us to provide you with a quote. Please include any brochures or descriptive materials that may assist us in a better understanding of your agency.

YOUR AGENCY

1. The precise name of your agency including any "D/B/A's" _____

_____

☐ For Profit ☐ Non-Profit ☐ Other Describe _____

2. Your mailing address: _____

City and State _____ Zip_____

Effective Date of Coverage:_____ Webpage address:_____

Please provide the addresses of all locations owned/leased by the insured to be covered:

STREET ADDRESS CITY AND STATE ZIP CODE OCCUPANCY/EXPOSURE

(1) _____

(2) _____

(3) _____

(4) _____

3. Please provide a brief description of your operations.

_____

_____

4. How long has your agency been in operation? _____ What is your annual budget? _____

a. Name all subsidiary companies/locations and other operations within applicant's control. _____

_____

b. Has applicant sold, acquired or discontinued any operations in the last 5 years? If yes, explain. _____

_____

5. Please give a complete percentage breakdown of your funding sources (total to equal 100%).

_____

6. Of what organizations or associations are you a member? (Please avoid use of acronyms)

_____

7. Are you aware of any state, federal, local code or professional ethics violations by your agency or any of your employees? ☐ Yes ☐ No

8. a. Does your state permit you to do criminal background investigations on prospective employees/volunteers? ☐ Yes ☐ No

b. If yes, do you routinely request and receive such background investigations? ☐ Yes ☐ No

c. Do you verify employment related references? ☐ Yes ☐ No

d. Do you verify educational requirements? ☐ Yes ☐ No

e. Do you conduct a personal interview? ☐ Yes ☐ No

f. Are licenses checked for employees/volunteers, when appropriate? ☐ Yes ☐ No

9. a. Do you discuss at staff orientation, physical and sexual abuse issues, how to recognize the signs and what to do if a client reports someone abused him/her? ☐ Yes ☐ No
b. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients? ☐ Yes ☐ No
c. Do you have a crisis management plan for dealing with staff, victim, parents, authorities and media if you have an incident of abuse? ☐ Yes ☐ No
d. Have you ever had an incident that resulted in an allegation of sexual abuse? ☐ Yes ☐ No
If yes, was a claim ever made against you? ☐ Yes ☐ No
(If yes, please give details on a separate sheet of paper including the date of the incident and any action taken by management to prevent from occurring again.)

10. Do you maintain training programs for your staff? ☐ Yes ☐ No
Describe training offered _____

YOUR OPERATIONS

11. PLEASE CHECK **YES or NO** TO THE SERVICE(S) BELOW THAT BEST DESCRIBE YOUR OPERATION.

a. RESIDENTIAL CARE

Do you operate any Residential Facilities? ☐ Yes ☐ No
(If "Yes", please complete a Residential Facility Questionnaire APA-160 for each facility.)

b. OUTPATIENT SERVICES

Provide annual number of appointments for the following services (each client's visit should be counted as an appointment) Include location no.:

YES	NO		No. of Appts	Loc No.
☐	☐	Drug & Alcohol Treatment: Individual	_____	_____
☐	☐	Drug & Alcohol Classes (DUI/DWI)	_____	_____
☐	☐	Mental Health Counseling: Individual	_____	_____
☐	☐	Mental Health Counseling: Group	_____	_____
☐	☐	MR Treatment Center	_____	_____
☐	☐	Cerebral Palsy Center	_____	_____
☐	☐	Rehabilitation Agency	_____	_____
☐	☐	Case Management (MH/MR/Comm. Support)	_____	_____
☐	☐	Training	_____	_____
☐	☐	Hospice (outpatient)	_____	_____
☐	☐	Family Skills Training	_____	_____
☐	☐	Independent Living Skills Training	_____	_____ on site Loc No. _____ _____ off site

c. **Provide number of clients/children per day and number of days per year that facility operates and at what location:**

YES	NO		**No. per day**	**No. of clients per year**	**No. of days**	**Loc**
☐	☐	Before & After School Care	_____	_____	_____	____
☐	☐	Headstart Program	_____	_____	_____	____
☐	☐	Well Child Day Care	_____	_____	_____	____

YES	NO		No. per day	No. of clients per year	No. of days	Loc
☐	☐	Day Camps for Mentally Ill or Developmentally Disabled	_____	_____	_____	____
☐	☐	Day Care for Mentally Ill or Dev. Dis.	_____	_____	_____	____
☐	☐	Sheltered Workshop/Work Activity				
☐	☐	Recreation Program	_____	_____	_____	____
☐	☐	Day Schools	_____	_____	_____	____
☐	☐	*Agencies for Aging/Senior Citizens	_____	_____	_____	____

*If yes, please describe the service provided for Agencies for Aging/Senior Citizens _____

_____

d. ☐ ☐ Foster and/or Adoption Placement Agency Loc No. _____
(If "Yes", please complete attached Foster/Adoption Placement Supplement APA-161.)

e. ☐ ☐ Home Care _____ Home Health Care _____ Respite Care _____ Loc No. ____
Age Range of Clients (please enter the number of clients in each age group):
Level of Care: Developmentally Disabled 0-17 _____ 18-60 _____ 60+ _____
Mentally Impaired 0-17 _____ 18-60 _____ 60+ _____
Other _____ _____ _____

Please describe services provided_____

_____

f. ☐ ☐	Methadone Maintenance Clinic	No. of Licensed Slots: _____	Loc No.	_____
g. ☐ ☐	Meals on Wheels	No. of Meals Annually: _____	Loc No.	_____
h. ☐ ☐	Hotline Center	No. of Calls Annually: _____	Loc No.	_____
i. ☐ ☐	Referral Agency	No. of Referrals Annually: ____	Loc No.	_____
j. ☐ ☐	CASA			
	(Court Appointed Special Advocates)	No. of Cases Assigned Annually:_____	Loc No.	_____
k. ☐ ☐	Mentorship	No. of Matches:_____	Loc No.	_____
	Center based____ Off-site based____	How often do they meet?_____	Loc No.	_____
l. ☐ ☐	Advocacy Services	No. of Clients Serviced:_____	Loc No.	_____
m.☐ ☐	Other Services not described above	Annual Client Contacts of Appointments:		
	_____	_____	Loc No.	_____
	_____	_____	Loc No.	_____
	_____	_____	Loc No.	_____

12. **STAFF**	**Employees**		**Non-Employees (Volunteers/Consultants)**	
	No. Full time	**No. Part Time**	**No. Full time**	**No. Part Time**
RN'S/LPN'S	_____	_____	_____	_____
Physicians Assts	_____	_____	_____	_____
Nurse Practitioners	_____	_____	_____	_____
Social Workers	_____	_____	_____	_____
Residence Managers	_____	_____	_____	_____
Counselors	_____	_____	_____	_____
Psychologist	_____	_____	_____	_____
If any Psychologists, are you requesting primary or excess coverage?			_____	
Others (specify)	_____	_____	_____	_____
_____	_____	_____	_____	_____

13. **EMPLOYED OR CONTRACTED PHYSICIANS AND PSYCHIATRISTS**
Do you want coverage for employed or contracted Physicians and Psychiatrists? ☐ Yes ☐ No
(If yes, complete the attached Physicians and Psychiatrists Liability Questionnaire APA-171.)
If yes, have you verified the credentials of the Physician(s) and/or Psychiatrist(s) that you are requesting coverage for? ☐ Yes ☐ No
If excess coverage is being requested, have you verified other insurance? ☐ Yes ☐ No

14. Do you provide any primary medical or skilled nursing services? ☐ Yes ☐ No If yes, please explain.

_____

15. Do you or any of your staff prescribe any medications? ☐ Yes ☐ No If yes, **please provide a list** on a separate sheet of paper of the medications, who prescribes them, for what purpose, and how they are secured.

16. Do you contract with any other facilities for additional beds? ☐ Yes ☐ No If yes, please indicate the number or estimated number of beds and provide a copy of the contract. No. of beds_____

17. Does your agency recommend release, parole or incarceration of clients? ☐ Yes ☐ No
(If yes, please explain on a separate sheet of paper.)

18. Do you treat any sexual offenders? ☐ Yes ☐ No
(If yes, please explain on a separate sheet of paper.)

19. Do you service clients recently released from a lock-up facility? ☐ Yes ☐ No
(Describe the nature of offenses on a separate sheet of paper.)

20. Are you licensed by the state(s) in which you operate? ☐ Yes ☐ No If No, is a license required? _____
(Please attach a copy of license and latest inspection)
If yes, is it renewed ☐ annually ☐ semi-annually ☐ other _____
Has your license ever been suspended or revoked? ☐ Yes ☐ No
If yes, please give details. _____

ADDITIONAL INSUREDS (PROFESSIONAL LIABILITY)

Insurable Interest - Check box that applies

Name: _____ ☐ Funding/Grant ☐ Contract/Services ☐ Other
Address:_____ Describe: _____
_____

Name: _____ ☐ Funding/Grant ☐ Contract/Services ☐ Other
Address:_____ Describe: _____
_____

Name: _____ ☐ Funding/Grant ☐ Contract/Services ☐ Other
Address:_____ Describe: _____
_____
_____

Name: _____ ☐ Funding/Grant ☐ Contract/Services ☐ Other
Address:_____ Describe: _____
_____
_____

COMMERCIAL GENERAL LIABILITY

21. Would you like to include Commercial General Liability coverage? ☐ Yes ☐ No **(If yes, please complete the following section and also attach a completed Acord General Liability Application.)**

LOCATION NO.	1	2	3	4
a. Year of Construction				
b. Number of Stories				
c. Which Stories are Occupied by Applicant?				
d. Area Occupied (sq ft)				
e. PROTECTIVE DEVICES	Yes No	Yes No	Yes No	Yes No
Automatic Sprinklers	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Heat Sensors	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Smoke Detectors	☐ ☐	☐ ☐	☐ ☐	☐ ☐
f. Fire Escapes or Exits	No.	No.	No.	No.
g. YEAR OF UPDATES IN CONSTRUCTION	Year:	Year:	Year:	Year:
	Yes No	Yes No	Yes No	Yes No
Plumbing	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Wiring	☐ ☐	☐ ☐	☐ ☐	☐ ☐

22. Do you lease or sub-lease to others any portion of the locations listed above? ☐ Yes ☐ No
If yes, do you require that your tenant carry liability insurance for the occupancy? ☐ Yes ☐ No
If yes, how often do you make sure the coverage is maintained? _____

23. Are there any pools at any of your locations? ☐ Yes ☐ No If yes, how many? _____ Loc No. _____
Are there spas or hot tubs at any of your locations? ☐ Yes ☐ No If yes, how many? _____ Loc No. _____
Are they used exclusively by your clients and/or staff? ☐ Yes ☐ No If no, describe the uses: _____
_____
Are they secured when not in use? ☐ Yes ☐ No Please describe security: _____
_____
Are clients supervised while using the pool and/or spa? ☐ Yes ☐ No Please describe methods: _____
_____

24. Is any construction or carpentry work done for clients or other parties? ☐ Yes ☐ No
(If Yes, please provide on a separate sheet, a detailed description of the work being performed.)

25. Will you be organizing or sponsoring any fundraising or special events during the next year? ☐ Yes ☐ No
If yes, please describe each event, including your role and the estimated amount of receipts:
_____ $_____
_____ $_____
_____ $_____

26. Do you participate in or supervise any sports activities for your clients? ☐ Yes ☐ No
If yes, please describe: _____

COMMERCIAL PROPERTY

27. Would you like to include Commercial Property coverage? ☐ Yes ☐ No **(If yes, please complete the following section and also attach a completed Acord Property Application. Note: Please Photocopy this Commercial Property Section and complete for additional locations.)**
    a. What is your total Building value for all locations? _____
    b. What is your total Business Personal Property value for all locations? _____
28. Is cooking allowed in each room? ☐ Yes ☐ No
29. Is there a central eating area? ☐ Yes ☐ No

30. Is there an adequate number of smoke detectors in public areas and in all living units and fire extinguishers located in easily accessible areas? ☐ Yes ☐ No
31. Do the smoke detectors and fire extinguishers have annual maintenance and certification? ☐ Yes ☐ No
32. Are there electrical powered smoke detectors? ☐ Yes ☐ No
33. Is all wiring with circuit breakers? ☐ Yes ☐ No
34. Are any buildings vacant, unoccupied, under renovation or under construction? ☐ Yes ☐ No
If yes, please explain_____

35. Are all buildings designed for present occupancy? ☐ Yes ☐ No
36. Are there any outstanding NFPA recommendations? ☐ Yes ☐ No
37. Do all exterior doors have dead bolts and windows with adequate locks? ☐ Yes ☐ No

38. Is this a non-smoking facility? ☐ Yes ☐ No
If no, where is the smoking area located _____
If no, is there a designated area for smoking and where is this area located? ☐ Yes ☐ No _____

39. Is the premises clean, neat and well lit? ☐ Yes ☐ No
40. Are any of the buildings used for low income housing, refugee facility or retail outlet? ☐ Yes ☐ No

NON-OWNED AUTO LIABILITY
(Please complete attached Non-Owned Auto Questionnaire APA-162.)

YOUR MOST RECENT INSURANCE HISTORY

LINE	COMPANY	LIMITS	PREMIUM	DED	EXPIRATION DATE	RETROACTIVE DATE
Professional Liability						
General Liability						
Excess and/or Umbrella						
Property/IM/ Crime						

41. If you have not purchased coverage before, please explain. _____
_____

42. Is your expiring professional liability and/or general liability coverage on a claims made basis? ☐ Yes ☐ No
If yes, would you like us to include prior acts coverage? ☐ Yes ☐ No
If yes, please provide proof of uninterrupted claims made coverage since the retroactive date.

43. Has any carrier cancelled or refused coverage for your agency? ☐ Yes ☐ No
(THIS QUESTION DOES NOT APPLY TO APPLICANTS IN MISSOURI)
If yes, please explain. _____

CLAIM INFORMATION
45. Have you had any claims and/or circumstances that have not been previously reported? ☐ Yes ☐ No
If yes, please attach detailed claim information with the date of the loss or occurrence, the status, the amount reserved or paid and a description of the claim or allegation.
Please attach 5 years loss history for all coverages requested.

46. Please describe your procedures when reporting potential incidents to the proper authorities. _____
_____

PLEASE READ THE FOLLOWING CAREFULLY

VIRGINIA, TENNESSEE FRAUD STATEMENT

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

ARIZONA FRAUD STATEMENT

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA FRAUD STATEMENT

For your protection, California law requires that you be made aware of the following: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO FRAUD STATEMENT

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA FRAUD STATEMENT

WARNING: It is a crime to provide false, or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

IDAHO FRAUD STATEMENT

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

INDIANA FRAUD STATEMENT

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LOUISIANA FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE FRAUD STATEMENT

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

MINNESOTA FRAUD STATEMENT

Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE FRAUD STATEMENT

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.

NEW JERSEY FRAUD STATEMENT – APPLICATION

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO FRAUD STATEMENT

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA FRAUD STATEMENT

WARNING – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

PENNSYLVANIA FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

VERMONT FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

FRAUD STATEMENT (All other states)

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE AND AGREEMENTS

(The following warranties do not apply to applicants in Arizona, Virginia and West Virginia, but signatures are still required)

The undersigned represents that all statements and answers to questions are true, complete and accurate and that there has been no suppression or misstatement of fact. The undersigned agrees that any policy issued will rely on the truth of the statements.

THE APPLICANT ACCEPTS NOTICE THAT HE/SHE IS REQUIRED TO PROVIDE WRITTEN NOTIFICATIONS TO THE COMPANY OF ANY CHANGES IN THE RESPONSES GIVEN TO THIS APPLICATION THAT MAY HAPPEN BETWEEN THE SIGNATURE DATE BELOW AND ANY PROPOSED EFFECTIVE DATE.

Except to such an extent as may be provided otherwise in the policy, the policy for which application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED and reported to the company while the policy is in force and which arise from services performed on or after the Retroactive Date of the policy.

The undersigned authorized representative of the applicant declares that (1) the statements set forth herein are true, (2) if the information supplied on this application changes between the date of this application and the effective date of the insurance, the undersigned will immediately notify his/her agent of such changes, and the company may withdraw or modify any outstanding quotations and/or agreement to bind insurance.

Date Signed _____ Signature of Applicant _____

Print Name and Title _____

This application form duly completed, together with any supplementary information must be signed in ink by the applicant

(The following warranties do not apply to applicants in Virginia and West Virginia but signatures are still required.)

THE PRODUCER REPRESENTS THAT ALL OF THE INSURANCE REQUIREMENTS OF THE APPLICANT'S HOME STATE HAVE BEEN OR WILL BE COMPLIED WITH. THIS INCLUDES THE SURPLUS LINES FILING AND THE SUBMITTING OF THE SURPLUS LINES FEES AND TAXES. THIS IS APPLICABLE IN ALL STATES EXCEPT CA, WA, AK AND CO. WE CAN DO FILINGS FOR YOU IN THOSE STATES IF NEEDED.

_____ _____ _____

Please Print Name Signature of Producer Date Signed

Producing Agency: _____

Address: _____

_____

Telephone: ( ) _____

SURPLUS LINES BROKER _____

SURPLUS LINES LICENSE NUMBER _____ FEIN NUMBER (FLORIDA ONLY) _____

Did you remember to?

If you are requesting Professional Liability coverage:
☐ Complete the Professional Liability Section of this application

If you are requesting General Liability coverage:
☐ Complete an Acord General Liability Application
☐ Complete the General Liability Section of this application

If you are requesting Property coverage:
☐ Complete an Acord Property Application
☐ Complete the Property Section of this application

If you are requesting Non-Owned Auto coverage:
☐ Complete the Non-Owned Auto Questionnaire

General Reminders:
☐ Did you complete each question in all applicable sections as we cannot offer a quote based on incomplete information?
☐ Did you sign and date all applications?
☐ Did you attach current loss runs?

SOCIAL SERVICE AGENCY

Application

CRC Insurance Services
10901 West Toller Drive, Suite 205
Littleton, CO 80127
Phone: 866-865-5727
Fax: 866-240-2807

CRC Insurance Services
10901 West Toller Drive, Suite 205, Littleton, CO 80127
Phone: 866-865-5727 Fax: 866-240-2807

Social Service Agency Application

This section is FOR OFFICE USE ONLY - Please do not complete.

☐ Diamond State Ins. Co. ☐ United National Ins. Co. ☐ United National Cas. Ins. Co. ☐ United National Spec. Ins. Co.

All questions must be completed to enable us to provide you with a quote. Please include any brochures or descriptive materials that may assist us in a better understanding of your agency.

YOUR AGENCY

1. The precise name of your agency including any "D/B/A's" _____

_____

☐ For Profit ☐ Non-Profit ☐ Other Describe _____

2. Your mailing address: _____
City and State _____ Zip_____
Effective Date of Coverage:_____ Webpage address:_____

Please provide the addresses of all locations owned/leased by the insured to be covered:

	STREET ADDRESS	CITY AND STATE	ZIP CODE	OCCUPANCY/EXPOSURE
(1)				
(2)				
(3)				
(4)				

3. Please provide a brief description of your operations.

_____

_____

4. How long has your agency been in operation? _____ What is your annual budget? _____

a. Name all subsidiary companies/locations and other operations within applicant's control. _____

_____

b. Has applicant sold, acquired or discontinued any operations in the last 5 years? If yes, explain. _____

_____

5. Please give a complete percentage breakdown of your funding sources (total to equal 100%).

_____

6. Of what organizations or associations are you a member? (Please avoid use of acronyms)

_____

7. Are you aware of any state, federal, local code or professional ethics violations by your agency or any of your employees? ☐ Yes ☐ No

8. a. Does your state permit you to do criminal background investigations on prospective employees/volunteers? ☐ Yes ☐ No

b. If yes, do you routinely request and receive such background investigations? ☐ Yes ☐ No

c. Do you verify employment related references? ☐ Yes ☐ No
d. Do you verify educational requirements? ☐ Yes ☐ No
e. Do you conduct a personal interview? ☐ Yes ☐ No
f. Are licenses checked for employees/volunteers, when appropriate? ☐ Yes ☐ No

9. a. Do you discuss at staff orientation, physical and sexual abuse issues, how to recognize the signs and what to do if a client reports someone abused him/her? ☐ Yes ☐ No
b. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients? ☐ Yes ☐ No
c. Do you have a crisis management plan for dealing with staff, victim, parents, authorities and media if you have an incident of abuse? ☐ Yes ☐ No
d. Have you ever had an incident that resulted in an allegation of sexual abuse? ☐ Yes ☐ No
If yes, was a claim ever made against you? ☐ Yes ☐ No
(If yes, please give details on a separate sheet of paper including the date of the incident and any action taken by management to prevent from occurring again.)

10. Do you maintain training programs for your staff? ☐ Yes ☐ No
Describe training offered _____

YOUR OPERATIONS

11. PLEASE CHECK **YES or NO** TO THE SERVICE(S) BELOW THAT BEST DESCRIBE YOUR OPERATION.

a. RESIDENTIAL CARE

Do you operate any Residential Facilities? ☐ Yes ☐ No
(If "Yes", please complete a Residential Facility Questionnaire APA-160 for each facility.)

b. OUTPATIENT SERVICES

Provide annual number of appointments for the following services (each client's visit should be counted as an appointment) Include location no.:

YES	NO		No. of Appts	Loc No.
☐	☐	Drug & Alcohol Treatment: Individual	_____	_____
☐	☐	Drug & Alcohol Classes (DUI/DWI)	_____	_____
☐	☐	Mental Health Counseling: Individual	_____	_____
☐	☐	Mental Health Counseling: Group	_____	_____
☐	☐	MR Treatment Center	_____	_____
☐	☐	Cerebral Palsy Center	_____	_____
☐	☐	Rehabilitation Agency	_____	_____
☐	☐	Case Management (MH/MR/Comm. Support)	_____	_____
☐	☐	Training	_____	_____
☐	☐	Hospice (outpatient)	_____	_____
☐	☐	Family Skills Training	_____	_____
☐	☐	Independent Living Skills Training	_____	_____ on site Loc No. _____ _____ off site

c. **Provide number of clients/children per day and number of days per year that facility operates and at what location:**

YES	NO		**No. per day**	**No. of clients per year**	**No. of days**	**Loc**
☐	☐	Before & After School Care	_____	_____	_____	____
☐	☐	Headstart Program	_____	_____	_____	____
☐	☐	Well Child Day Care	_____	_____	_____	____

YES	NO		No. per day	No. of clients per year	No. of days	Loc
☐	☐	Day Camps for Mentally Ill or Developmentally Disabled	_____	_____	_____	____
☐	☐	Day Care for Mentally Ill or Dev. Dis.	_____	_____	_____	____
☐	☐	Sheltered Workshop/Work Activity Recreation Program	_____	_____	_____	____
☐	☐	Day Schools	_____	_____	_____	____
☐	☐	*Agencies for Aging/Senior Citizens	_____	_____	_____	____

*If yes, please describe the service provided for Agencies for Aging/Senior Citizens _____

_____

d. ☐ ☐ Foster and/or Adoption Placement Agency Loc No. _____
(If "Yes", please complete attached Foster/Adoption Placement Supplement APA-161.)

e. ☐ ☐ Home Care _____ Home Health Care _____ Respite Care _____ Loc No. ____
Age Range of Clients (please enter the number of clients in each age group):
Level of Care: Developmentally Disabled 0-17 _____ 18-60 _____ 60+ _____
Mentally Impaired 0-17 _____ 18-60 _____ 60+ _____
Other _____ _____ _____

Please describe services provided_____

_____

f. ☐ ☐	Methadone Maintenance Clinic	No. of Licensed Slots: _____	Loc No.	_____
g. ☐ ☐	Meals on Wheels	No. of Meals Annually: _____	Loc No.	_____
h. ☐ ☐	Hotline Center	No. of Calls Annually: _____	Loc No.	_____
i. ☐ ☐	Referral Agency	No. of Referrals Annually: ____	Loc No.	_____
j. ☐ ☐	CASA (Court Appointed Special Advocates)	No. of Cases Assigned Annually:_____	Loc No.	_____
k. ☐ ☐	Mentorship	No. of Matches:_____	Loc No.	_____
	Center based____ Off-site based____	How often do they meet?_____	Loc No.	_____
l. ☐ ☐	Advocacy Services	No. of Clients Serviced:_____	Loc No.	_____
m.☐ ☐	Other Services not described above	Annual Client Contacts of Appointments:		
	_____	_____	Loc No.	_____
	_____	_____	Loc No.	_____
	_____	_____	Loc No.	_____

12. **STAFF**	**Employees**		**Non-Employees (Volunteers/Consultants)**	
	No. Full time	**No. Part Time**	**No. Full time**	**No. Part Time**
RN'S/LPN'S	_____	_____	_____	_____
Physicians Assts	_____	_____	_____	_____
Nurse Practitioners	_____	_____	_____	_____
Social Workers	_____	_____	_____	_____
Residence Managers	_____	_____	_____	_____
Counselors	_____	_____	_____	_____
Psychologist	_____	_____	_____	_____
If any Psychologists, are you requesting primary or excess coverage?			_____	
Others (specify)	_____	_____	_____	_____
_____	_____	_____	_____	_____

13. **EMPLOYED OR CONTRACTED PHYSICIANS AND PSYCHIATRISTS**
Do you want coverage for employed or contracted Physicians and Psychiatrists? ☐ Yes ☐ No
(If yes, complete the attached Physicians and Psychiatrists Liability Questionnaire APA-171.)
If yes, have you verified the credentials of the Physician(s) and/or Psychiatrist(s) that you are requesting coverage for? ☐ Yes ☐ No
If excess coverage is being requested, have you verified other insurance? ☐ Yes ☐ No

14. Do you provide any primary medical or skilled nursing services? ☐ Yes ☐ No If yes, please explain.

_____

15. Do you or any of your staff prescribe any medications? ☐ Yes ☐ No If yes, **please provide a list** on a separate sheet of paper of the medications, who prescribes them, for what purpose, and how they are secured.

16. Do you contract with any other facilities for additional beds? ☐ Yes ☐ No If yes, please indicate the number or estimated number of beds and provide a copy of the contract. No. of beds_____

17. Does your agency recommend release, parole or incarceration of clients? ☐ Yes ☐ No
(If yes, please explain on a separate sheet of paper.)

18. Do you treat any sexual offenders? ☐ Yes ☐ No
(If yes, please explain on a separate sheet of paper.)

19. Do you service clients recently released from a lock-up facility? ☐ Yes ☐ No
(Describe the nature of offenses on a separate sheet of paper.)

20. Are you licensed by the state(s) in which you operate? ☐ Yes ☐ No If No, is a license required? _____
(Please attach a copy of license and latest inspection)
If yes, is it renewed ☐ annually ☐ semi-annually ☐ other _____
Has your license ever been suspended or revoked? ☐ Yes ☐ No
If yes, please give details. _____

ADDITIONAL INSUREDS (PROFESSIONAL LIABILITY)

Insurable Interest - Check box that applies

Name: _____ ☐ Funding/Grant ☐ Contract/Services ☐ Other
Address:_____ Describe: _____
_____

Name: _____ ☐ Funding/Grant ☐ Contract/Services ☐ Other
Address:_____ Describe: _____
_____

Name: _____ ☐ Funding/Grant ☐ Contract/Services ☐ Other
Address:_____ Describe: _____
_____
_____

Name: _____ ☐ Funding/Grant ☐ Contract/Services ☐ Other
Address:_____ Describe: _____
_____
_____

COMMERCIAL GENERAL LIABILITY

21. Would you like to include Commercial General Liability coverage? ☐ Yes ☐ No **(If yes, please complete the following section and also attach a completed Acord General Liability Application.)**

LOCATION NO.	1	2	3	4
a. Year of Construction				
b. Number of Stories				
c. Which Stories are Occupied by Applicant?				
d. Area Occupied (sq ft)				
e. PROTECTIVE DEVICES	Yes No	Yes No	Yes No	Yes No
Automatic Sprinklers	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Heat Sensors	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Smoke Detectors	☐ ☐	☐ ☐	☐ ☐	☐ ☐
f. Fire Escapes or Exits	No.	No.	No.	No.
g. YEAR OF UPDATES IN CONSTRUCTION	Year:	Year:	Year:	Year:
	Yes No	Yes No	Yes No	Yes No
Plumbing	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Wiring	☐ ☐	☐ ☐	☐ ☐	☐ ☐

22. Do you lease or sub-lease to others any portion of the locations listed above? ☐ Yes ☐ No
If yes, do you require that your tenant carry liability insurance for the occupancy? ☐ Yes ☐ No
If yes, how often do you make sure the coverage is maintained? _____

23. Are there any pools at any of your locations? ☐ Yes ☐ No If yes, how many? _____ Loc No. _____
Are there spas or hot tubs at any of your locations? ☐ Yes ☐ No If yes, how many? _____ Loc No. _____
Are they used exclusively by your clients and/or staff? ☐ Yes ☐ No If no, describe the uses: _____
_____
Are they secured when not in use? ☐ Yes ☐ No Please describe security: _____
_____
Are clients supervised while using the pool and/or spa? ☐ Yes ☐ No Please describe methods: _____
_____

24. Is any construction or carpentry work done for clients or other parties? ☐ Yes ☐ No
(If Yes, please provide on a separate sheet, a detailed description of the work being performed.)

25. Will you be organizing or sponsoring any fundraising or special events during the next year? ☐ Yes ☐ No
If yes, please describe each event, including your role and the estimated amount of receipts:
_____ $_____
_____ $_____
_____ $_____

26. Do you participate in or supervise any sports activities for your clients? ☐ Yes ☐ No
If yes, please describe: _____

COMMERCIAL PROPERTY

27. Would you like to include Commercial Property coverage? ☐ Yes ☐ No **(If yes, please complete the following section and also attach a completed Acord Property Application. Note: Please Photocopy this Commercial Property Section and complete for additional locations.)**
    a. What is your total Building value for all locations? _____
    b. What is your total Business Personal Property value for all locations? _____
28. Is cooking allowed in each room? ☐ Yes ☐ No
29. Is there a central eating area? ☐ Yes ☐ No

30. Is there an adequate number of smoke detectors in public areas and in all living units and fire extinguishers located in easily accessible areas? ☐ Yes ☐ No
31. Do the smoke detectors and fire extinguishers have annual maintenance and certification? ☐ Yes ☐ No
32. Are there electrical powered smoke detectors? ☐ Yes ☐ No
33. Is all wiring with circuit breakers? ☐ Yes ☐ No
34. Are any buildings vacant, unoccupied, under renovation or under construction? ☐ Yes ☐ No
If yes, please explain_____

35. Are all buildings designed for present occupancy? ☐ Yes ☐ No
36. Are there any outstanding NFPA recommendations? ☐ Yes ☐ No
37. Do all exterior doors have dead bolts and windows with adequate locks? ☐ Yes ☐ No

38. Is this a non-smoking facility? ☐ Yes ☐ No
If no, where is the smoking area located _____
If no, is there a designated area for smoking and where is this area located? ☐ Yes ☐ No _____

39. Is the premises clean, neat and well lit? ☐ Yes ☐ No
40. Are any of the buildings used for low income housing, refugee facility or retail outlet? ☐ Yes ☐ No

NON-OWNED AUTO LIABILITY
(Please complete attached Non-Owned Auto Questionnaire APA-162.)

YOUR MOST RECENT INSURANCE HISTORY

LINE	COMPANY	LIMITS	PREMIUM	DED	EXPIRATION DATE	RETROACTIVE DATE
Professional Liability						
General Liability						
Excess and/or Umbrella						
Property/IM/ Crime						

41. If you have not purchased coverage before, please explain. _____
_____

42. Is your expiring professional liability and/or general liability coverage on a claims made basis? ☐ Yes ☐ No
If yes, would you like us to include prior acts coverage? ☐ Yes ☐ No
If yes, please provide proof of uninterrupted claims made coverage since the retroactive date.

43. Has any carrier cancelled or refused coverage for your agency? ☐ Yes ☐ No
(THIS QUESTION DOES NOT APPLY TO APPLICANTS IN MISSOURI)
If yes, please explain. _____

CLAIM INFORMATION

46. Have you had any claims and/or circumstances that have not been previously reported? ☐ Yes ☐ No
If yes, please attach detailed claim information with the date of the loss or occurrence, the status, the amount reserved or paid and a description of the claim or allegation.
Please attach 5 years loss history for all coverages requested.

47. Please describe your procedures when reporting potential incidents to the proper authorities. _____

_____

PLEASE READ THE FOLLOWING CAREFULLY

VIRGINIA, TENNESSEE FRAUD STATEMENT

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

ARIZONA FRAUD STATEMENT

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA FRAUD STATEMENT

For your protection, California law requires that you be made aware of the following: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO FRAUD STATEMENT

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA FRAUD STATEMENT

WARNING: It is a crime to provide false, or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

IDAHO FRAUD STATEMENT

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

INDIANA FRAUD STATEMENT

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LOUISIANA FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE FRAUD STATEMENT

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

MINNESOTA FRAUD STATEMENT

Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE FRAUD STATEMENT

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.

NEW JERSEY FRAUD STATEMENT – APPLICATION

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO FRAUD STATEMENT

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OKLAHOMA FRAUD STATEMENT

WARNING – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON FRAUD STATEMENT

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The undersigned represents that all statements and answers to questions are true, complete and accurate and that there has been no suppression or misstatement of fact. The undersigned agrees that any policy issued will rely on the truth of the statements.

THE APPLICANT ACCEPTS NOTICE THAT HE/SHE IS REQUIRED TO PROVIDE WRITTEN NOTIFICATIONS TO THE COMPANY OF ANY CHANGES IN THE RESPONSES GIVEN TO THIS APPLICATION THAT MAY HAPPEN BETWEEN THE SIGNATURE DATE BELOW AND ANY PROPOSED EFFECTIVE DATE.

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The undersigned authorized representative of the applicant declares that (1) the statements set forth herein are true, (2) if the information supplied on this application changes between the date of this application and the effective date of the insurance, the undersigned will immediately notify CRC of such changes, and CRC may withdraw or modify any outstanding quotations and/or agreement to bind insurance.

Date Signed _____ Signature of Applicant _____

Print Name and Title _____

This application form duly completed, together with any supplementary information must be signed in ink by the applicant

(The following warranties do not apply to applicants in Virginia and West Virginia but signatures are still required.)

THE PRODUCER REPRESENTS THAT ALL OF THE INSURANCE REQUIREMENTS OF THE APPLICANT'S HOME STATE HAVE BEEN OR WILL BE COMPLIED WITH. THIS INCLUDES THE SURPLUS LINES FILING AND THE SUBMITTING OF THE SURPLUS LINES FEES AND TAXES. THIS IS APPLICABLE IN ALL STATES EXCEPT CA, WA, AK AND CO. WE CAN DO FILINGS FOR YOU IN THOSE STATES IF NEEDED.

Please Print Name	Signature of Producer submitting to CRC ☐ Retailer ☐ Wholesaler	Date Signed

Producing Agency submitting to CRC: _____

Address: _____

_____

Telephone: ( ) _____

SURPLUS LINES BROKER _____

SURPLUS LINES LICENSE NUMBER _____ FEIN NUMBER (FLORIDA ONLY) _____

Did you remember to?

If you are requesting Professional Liability coverage:
☐ Complete the Professional Liability Section of this application

If you are requesting General Liability coverage:
☐ Complete an Acord General Liability Application
☐ Complete the General Liability Section of this application

If you are requesting Property coverage:
☐ Complete an Acord Property Application
☐ Complete the Property Section of this application

If you are requesting Non-Owned Auto coverage:
☐ Complete the Non-Owned Auto Questionnaire

General Reminders:
☐ Did you complete each question in all applicable sections as we cannot offer a quote based on incomplete information?
☐ Did you sign and date all applications?
☐ Did you attach current loss runs?

SERFF Tracking Number:	*PENN-125601891*	*State:*	*Arkansas*
Filing Company:	*Diamond State Insurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*DS-2008-PL-F-080*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0000 Other Liability Sub-TOI Combinations*
Product Name:	*Social Services Program*		
Project Name/Number:	*/DS-2008-PL-F-080*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PENN-125601891*	*State:*	*Arkansas*
Filing Company:	*Diamond State Insurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*DS-2008-PL-F-080*		
TOI:	*17.0 Other Liability - Claims Made/Occurrence*	*Sub-TOI:*	*17.0000 Other Liability Sub-TOI Combinations*
Product Name:	*Social Services Program*		
Project Name/Number:	*/DS-2008-PL-F-080*		

Supporting Document Schedules

		Review Status:	
Satisfied -Name:	Uniform Transmittal Document-Property & Casualty	Approved	04/16/2008

Comments:

Attachment:

AR P&C Transmittal.pdf

Effective March 1, 2007

Property & Casualty Transmittal Document

Reset Form

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only
	a. Date the filing is received:
	b. Analyst:
	c. Disposition:
	d. Date of disposition of the filing:
	e. Effective date of filing:
	New Business
	Renewal Business
	f. State Filing #:
	g. SERFF Filing #:
	h. Subject Codes

3.	Group Name	Group NAIC #
	United National Group	920

4.	Company Name(s)	Domicile	NAIC #	FEIN #	State #
	Diamond State Insurance Company	IN	42048	51-0257823	

5.	Company Tracking Number	DS-2008-PL-F-080

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Lorna Geiger Three Bala Cynwyd East, Ste 300 Bala Cynwyd, PA 19004	State Filing Analyst	610-660-6876	610-660-3399	lgeiger@uai-group.com

7.	Signature of authorized filer	Lorna Geiger Digitally signed by Lorna Geiger DN: cn=Lorna Geiger, c=US, o=UAI, email=lgeiger@unitednat.com Date: 2008.04.10 10:52:56 -04'00'
8.	Please print name of authorized filer	Lorna Geiger

Filing information (see General Instructions for descriptions of these fields)

9.	**Type of Insurance (TOI)**	17.0 Other Liability-Occ/Claims Made
10.	**Sub-Type of Insurance (Sub-TOI)**	17.0001 Commercial General Liability
11.	**State Specific Product code(s)(if applicable)[See State Specific Requirements]**	
12.	**Company Program Title (**Marketing title)	Social Service Program
13.	**Filing Type**	☐ Rate/Loss Cost ☐ Rules ☐ Rates/Rules ☑ Forms ☐ Combination Rates/Rules/Forms ☐ Withdrawal ☐ Other (give description)
14.	**Effective Date(s) Requested**	New: 06/01/2008 Renewal:
15.	**Reference Filing?**	☐ Yes ☑ No
16.	**Reference Organization (**if applicable)	
17.	**Reference Organization # & Title**	
18.	**Company's Date of Filing**	
19.	**Status of filing in domicile**	☐ Not Filed ☑ Pending ☐ Authorized ☐ Disapproved

Property & Casualty Transmittal Document—

20.	**This filing transmittal is part of Company Tracking #**	DS-2008-PL-F-080

21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

Diamond State Insurance Company is filing a revision to its currently approved Social Services Program. We are submitting revised form APA-159 (01/2008), Social Service Agency Application, which will replace APA-159 (11/05) on approval. The following changes have been made to the form:

1. The Accident and Health section has been removed from page 7 of 11 along with questions 41 and 42 which applied to this section;
2. Questions 41 and 42 have been renumbered;
3. Reference to NIPC has replaced with CRC on page 10 of 11; and
4. The Reminder regarding Accident and Health has been deleted on page 11 of 11.

We are also submitting new form APA-159A (01/2008), Diamond State Group Social Services Agencies Application. Form APA-159 will be used for our MGA (CRC) and form APA-159A will be used for brokerage business. Form APA-159A is basically the same as APA-159 with the following changes:

1. The cover sheet has the following changes:
a) The Diamond State logo has been added;
b) The wording “Social Services Agency Application” has been moved down the page and is now referred to as “Social Services Agencies Application";
c) "CRC” has been deleted
d) The office address, telephone number, and fax number have been added in the lower right hand corner.
2. Questions 41 and 42 have been renumbered;
3. Reference to NIPC/CRC has been deleted ;
4. Check boxes labeled “Retailer” and “Wholesaler” have been removed on page 10 of 11;
5. The Reminder regarding Accident and Health has been deleted on page 11 of 11; and
6.The form has been renamed APA-159A (01/2008).

View Complete Filing Description

22. Filing Fees (Filer must provide check # and fee amount if applicable)
[If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #: EFT
Amount: $50.00

Refer to each state’s checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state’s checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

Effective March 1, 2007

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)

(Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1.	**This filing transmittal is part of Company Tracking #**	DS-2008-PL-F-080
2.	**This filing corresponds to rate/rule filing number** (Company tracking number of rate/rule filing, if applicable)	

3.	**Form Name /Description/Synopsis**	**Form # Include edition date**	**Replacement Or withdrawn?**	**If replacement, give form # it replaces**	**Previous state filing number,** if required by state
01	APA-159A	(01/2008)	☑ New ☐ Replacement ☐ Withdrawn		
02	APA-159	(01/2008)	☐ New ☑ Replacement ☐ Withdrawn	APA-159 (11/05)	
03			☐ New ☐ Replacement ☐ Withdrawn		
04			☐ New ☐ Replacement ☐ Withdrawn		
05			☐ New ☐ Replacement ☐ Withdrawn		
06			☐ New ☐ Replacement ☐ Withdrawn		
07			☐ New ☐ Replacement ☐ Withdrawn		
08			☐ New ☐ Replacement ☐ Withdrawn		
09			☐ New ☐ Replacement ☐ Withdrawn		
10			☐ New ☐ Replacement ☐ Withdrawn		

PC FFS-1